PLEASE USE A BLACK BALL POINT PEN TO COMPLETE FORM

COBRA Health Insurance Information

Case #: _____

- This form MUST be completed by your previous employer or your COBRA insurance company representative.
- Any blanks left on this form may delay the process.

A General Information

Policy Holder Name : _____ SS#: _____

Insurance Plan Name: _____

☐Yes ☐No 1. Is the individual eligible to enroll in COBRA coverage?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

☐Yes ☐No 2. Is the individual or any family member enrolled in COBRA coverage?
If yes, name(s) of persons enrolled: _____
_____
_____

☐Yes ☐No 3. Has the individual or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

B COBRA Plan

Questions below refer to the ***COBRA*** plan offered at your company.

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) _____

3. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	ARRA's* Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

4. Please list the yearly health plan deductible (not the "out of pocket" cost or hospital deductible).
Individual amount $_____ Family amount $_____

☐Yes ☐No 5. Does the plan pay for any services (doctor, pharmacy, etc.) before the employee has met the deductible listed above?

6. When will ARRA* premium reduction end? (mm/dd/yy) _____

* American Recovery and Reinvestment Act

(continued)

Policy Holder Name: _____ SS#: _____ Case #: _____

C Applicant's Health Plan Choice

Questions below refer to the plan the employee has selected. Questions 2-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____

☐Yes ☐No 2. Is the deductible $2,500 or less per individual?

☐Yes ☐No 3. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

5. What benefits are covered under this plan? (Check all that apply.)
   - ☐ Physician visits
   - ☐ Hospital inpatient services
   - ☐ Pharmacy/Rx
   - ☐ Well child exams
   - ☐ Child immunizations

☐Yes ☐No 6. Are the individual's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
   - ☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
   - ☐ Other, please describe: _____

D Signature

I certify that I am the applicant's former employer or that I am the COBRA insurance company representative. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500
Toll-free Fax: 877-313-4717